STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150154	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HEART HOSPITAL THE	8075 N SHADELAND AVE INDIANAPOLIS, IN46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	This visit was for a standard licensure survey. Facility Number: 003312 Survey Date: 7-18/20-11 Surveyors: Jack I. Cohen, MHA Medical Surveyor John Lee, RN Public Health Nurse Surveyor Albert Daeger Medical Surveyor QA: claughlin 08/09/11	S0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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S0178	410 IAC 15-1.3-2(a) (a)The license shall be conspicuously posted on the hospital premises in an area open to patients and public. A copy shall be conspicuously posted in an area open to patients and public on the premises of each separate hospital building of a multiple hospital building system. Based on observation, the hospital failed to conspicuously post the hospital license in an area open to patients and the public at one (1) offsite. Findings: 1. On 7-18-11 at 12:40 pm in the presence of employees #A6 and #A14, it was observed in the Cardiac Testing offsite department that there was no hospital license posted in an area open to patients and the public.	S0178	The Indiana Heart Hospital license was posted in the Cardiac Testing off-site on 7/18/11 during the survey.Ongoing compliance and monitoring:The license will remain posted in the Cardiac Testing Center until the 2012 license is granted. The Cardiac Testing Supervisor is responsible to see that the new license is posted by January 1, 2012.	07/20/2011

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S0308	15-1.4-2 (c)(6)(B) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (B) Orientation of all new employees, including contract and agency personnel, to applicable hospital, department, service, and personnel policies.			
	Based on document review and interview, the hospital failed to orient 4 of 12 employees to applicable department policies, per facility policy. Findings: 1. Review of POLICY NUMBER: 13B indicated [there is a] department orientation process. 2. Review of 12 personnel files indicated files PF#6, PF#8, PF#10 and PF#12 did not contain any documentation of department orientation. 3. On 7-18-20-11 at 10:15 am, employee #A1 was requested to provide the above documentation. 4. On 7-20-11 at 10:30 am, upon	S0308	Deficiencies identified above included Department Orientation Sheets present in the employee file, but not properly signed and/or dated, as well as several employee files void of the complete Department Orientation Sheets.As such, re-education and reinforcement of Policy 13B - Competency Assessment, with the management staff of TIHH was initiated beginning August 4, 2011 by Human Resources and will be completed by October 1, 2011.Employee files will be audited to insure that proper documentation of the Department Orientation has been maintained on each employee by Human Resources and will be completed by October 1, 2011.In cases where the Department Orientation sheet has not been maintained and is not available, employees will be reoriented and a replacement Department Orientation sheet will	10/01/2011

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	interview, employee #A16 indicated there was no documentation and none was provided prior to exit.		be completed with a notation indicating that the document is in place of the original that was found to be missing. This is to be completed by Human Resources by October 1, 2011.	
S0312	410 IAC 15-1.4-1(c)(6)(D) (c) The governing board is responsible for managing the hospital. The governing board shall do the following: (6) Require that the chief executive officer develops policies and programs for the following: (D) Annual performance evaluations, based on a job description, for each employee providing direct patient care or support services, including contract and agency personnel, who are not subject to a clinical privileging process. Based on document review and interview, the facility failed to conduct, per facility policy, a performance evaluation for 4 of 12 employee files reviewed. Findings: 1. Review of POLICY NUMBER: 13B, indicated there will be an annual PA [Performance Assessment]. 2. Review of 12 personnel files indicated files PF#7, PF#8, PF#10 and PF#11, all	S0312	Each employmentt ffle reviewed had a Perfformance Appraisal (PA)documentt The employees identtffed above as having no Perfformance Appraisal ffell intto one off tthe tthree ffollowing cattegories PA was completted on Communitty Healtth Nettwork fform butt was signed by a conttractt supervisor and/or conttractt departtmentt leaderand nott signed by anyone ffrom The Indiana Heartt Hospitta(TIHH), tthereffore tthe surveyor did nott recognize tthe PA as being completted PA was completted on Communitty Healtth Nettwork fform butt was signed	10/01/2011

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	contracted, did not contain any documentation of performance evaluation performed by an authorized hospital person or if done by a non-hospital person, reviewed and signed by an authorized hospital person. 3. On 7-20-11, employee #A16 was requested to provide the above documentation and upon interview, indicated there was none and no appropriate documentation was provided prior to exit.		by a departtmentt supervisor or departtmentt leader tthatt is a Communitty Healtth Nettwork employee butt was nott recognized by tthe surveyor as an employee off TIHH, tthereffore tthe PA was nott countted as completted As Communitty Healtth Nettwork legally ttransittoned ffrom ffve separatte employmentt entttes intto one employer on December 27, 2010, tthe signattures on tthe Perfformance Appraisals do qualiffy as a complette perfformance appraisals PA was completted on a conttractt employee by a conttractt supervisor butt tthe PA completted was nott a Communitty Healtth Nettwork PA fform tthereffore tthe PA was nott countted as completted by tthe surveyor. **REMEDY:** Remedies include aligning written polices tto clearly identtffy who is autthorized tto complette and sign a Perfformance Appraisal as well as sttpulatte tthatt all conttractt employees mustt be reviewed on tthe Communitty Healtth Nettwork PA fform Policy revisions tto be effecttve Septtember1, 2011. **13 B COMPETENCY ASSESSMENT revised tio stiatie tihe following (highlightied sections indicatie revisions):** **STATEMENT OF PURPOSE:** Communitty will mainttain a systtem tthatt provides ffor tthe inittal and	

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			ongoing periodic evaluatton off employees' conttnuing abilittes tto perfform, tthroughoutt ttheir associatton witth tthe Nettwork Conttractt employees will be held tto tthe same evaluatton off competency processes as regular employees. **PROCEDURES:** B. Att tthe annual "PA Datte" signiffcantt competencies mustt be documentted The PA datte ffor conttractted employees will be Septtember30 tth each consisttentt witth all TIHH sttaff *C. All contiractied employees will be evaluatied on tihe Communitiy Healtih Netiwork Perfiormance Appraisal fiorm or an equivalenti fiorm tihati has been approved by Communitiy Healtih Netiwork Human Resources.* **PERFORMANCE APPRAISAL AND MERIT INCREASE POLICY revised tio stiatie tihe following** **POLICY:** A. Unless a departtmentt receives speciffc autthorizatton ffrom itts Senior Leader and ffrom Human Resources itt mustt provide annual perfformance reviews tto itts sttaff as described in tthis policy. *B. Contiracti employees will be reviewed using tihe Communitiy Healtih Netiwork Perfiormance Appraisal fiorm or an equivalenti fiorm tihati has been approved by Communitiy Healtih Netiwork Human*	

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			Resources. *C. Perfiormance Appraisals may be conductied by tihe employee's or contiracti employee's directi supervisor or departimenti leader The directi supervisor or departimenti leader is defined as an employee ofi The Indiana Hearti Hospitia(TIHH) or Communitiy Healtih Netiwork (CHNw). (see Employmenti Policy – Communitiy Healtih Netiwork Employmenti Relationships). Additionally, a contiracti supervisor or contiracti departimenti leader tihati is contiractied by The Indiana Hearti Hospitial or Communitiy Healtih Netiwork in a role supervising TIHH Communitiy Healtih Netiwork and/or contiracti employees has tihe autihoritiy tio conducti and sign tihe Perfiormance Appraisa fiollowing tihe policy and process as identified in tihis policy.* **EMPLOYMENT POLICY revised tio stiatie tihe following** *8. Community Health Network Employment Relationships: Community Health Network became a single employer on December 27, 2010. This action brought the previous separate employer entities of the organization into a single employment company. As a result, all Community Health Network entities covered by this policy (see policy header) have agreed to recognize and accept each other's prior employment*	

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			documents and files including employee training, orientation, competencies, applicable background checks, application(s), role summaries, Employee Health records and other necessary employment documents associated with a Community Health Network entity (see policy header), created or established prior to December 27, 2010. (See Community Health Network Master Agreement for additional operational detail). **SBOH Citiation Texti** Based on documentt review and intterviewy tthe hospittal ffailed tto orientt4 off 12employees tto applicable departttmentt policies,per ffacilitty policy Findings: Review off POLICY NUMBER13B indicatted tthere is a departtmentt orienttatton process Review off12 personnel ffles indicatted ffles P#6, PF#8, PF#10 and PF#12 did nott conttain any documenttatton off departtmentt orienttatton. On 7-20-11 att10:15 a.m., employee #A1 was requestted tto provide tthe above infformatton. On 7-20-11 att10:30 a.m., upon intterviewy employee #A16 indicatted tthere was no documenttatton and	

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			none was provided prior tto exitt **RESPONSE:** Deffciencies identtffed above included Departtmentt Orienttatton Sheetts presentt in tthe employee ffle butt nott properly signed and/or datted as well as several employee ffles void off tthe completted Departtmentt Orienttatton Sheetts **REMEDY:** Re-educatton and reinfforcementt off Policy 13 B- Competency Assessmentt witth tthe managementt sttaff off TIHH was inittatted beginning Augustt4, 2011. Employee ffles will be auditted tto insure tthatt proper documenttatton off tthe Departtmentt Orienttatton has been signed and mainttained on each employee. In cases where tthe Departtmentt Orienttatton sheett has nott been mainttained and is nott availble employees will be re-orientted and a replacementt Departtmentt Orienttatton sheett will be completted witth a nottatton indicattng tthatt tthe documentt is in place off tthe original tthatt was ffound tto be missing or unsigned. This process tto be completted by Octtober1, 2011.	

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S0406	410 IAC 15-1.4-2(a)(1) (a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: (1) All services, including services furnished by a contractor. Based on document review and interview, the hospital failed to include 4 services provided by a contractor as part of its comprehensive quality assessment and improvement (QA&I) program. Findings: 1. Review of the facility's QA&I program indicated it did not include the contracted services of biohazardous waste, housekeeping, laundry and pharmacy. 2. On 7-20-11 at 3:30 pm, employee #A1 was requested to provide the above documentation. Upon interview, the employee indicated there was none and no documentation was provided prior to exit.	S0406	Laundry and biohazardous waste will be added to the Department Indicator Dashboard. Environmental Services and Pharmacy are on the Department Indicator Dashboard. Both of these departments have Managers that are a part of a Network Team. These Managers are included in a Master's Agreement between the Network and the Indiana Heart Hospital and these Managers are included in the Department Indicators for Pharmacy and Environmental Services.Ongoing monitoring and compliance:These indicators will be reviewed monthly by the QR Site Leader and Departmental leadership for ongoing compliance.	10/01/2011

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S0554	410 IAC 15-1.5-2(a) (a) The hospital shall provide a safe and healthful environment that minimizes infection exposure and risk to patients, health care workers, and visitors. Based on observation and interview, the facility failed to provide a safe and healthful environment that minimizes infection exposure and risk to patients for 1 Emergency Department (ED). Findings include: 1. On 07-18-11 at 1145 hours during the facility tour of the ED the following items were observed in Equipment Cart and in the Crash Cart: 1 500 ml bag of sterile H2O with an expiration date of 07-01-11. 1 Pneumothorax kit with an expiration date of 06-11. 3 pink top laboratory tubes with an expiration date of 08-10. 4 green top laboratory tubes with an expiration date of 02-11. 2 red top laboratory tubes with an expiration date of 03-11. 4 blue top laboratory tubes with an expiration date of 03-11. 4 yellow laboratory tubes with an expiration date of 10-10. 2 portacath plus kits with an expiration	S0554	All expired items were removed and discarded immediately during the survey. The process for stocking and checking equipment and crash carts was re-evaluated and reviewed with staff responsible for checking outdates.Based on the findings, effective September 1st, 2011, the following practice for the ED at TIHH was implemented:1. The crash cart and equipment cart check lists will reflect a check by the ED staff on a monthly basis.2. All lab tubes will be checked by an ED staff person on a monthly basis, the equipment cart check list will include lab tube checks. (one form)3. The monthly check lists will be verified and signed by the ED Nurse Manager as completed.4. The Nurse Manager will bring a signed copy of the check list to the ED Director during the monthly Director/Manager rounds meeting.5. The ED Director will include this in the monthly report to the CNO/VP of PCS during the monthly CNO/Director rounds.Monitoring for compliance:The ED Director, or her delegates, are responsible for the ongoing monitoring of outdated items and will be doing	09/01/2011

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	date of 02-11. 2 multilumen kits with an expiration date of 04-10 and 07-11. 4 saline flush 10 ml syringes with an expiration date of 11-01-10. 1 multilumen cath kit with an expiration date of 12-09. 1 500 ml normal saline bag with an expiration date of 12-01-09. 2. On 07-18-11 at 1145 hours, staff #51 confirmed that the above items were expired.		random checks to assure compliance and prevent future recurrence.	
S0608	410 IAC 15-1.5-2(f)(3)(D)(ix) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (ix) Requirements for personal hygiene and attire appropriate for work settings. Based on observation and interview, the facility failed to ensure all staff working in the Blood Bank are wearing personnel	S0608	The Point of Care Coordinator has a computer/office area in a section of the lab. This work station is considered a clean station. We have now posted	07/20/2011

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	protective equipment (PPE) to protect from possible infectious exposure. Findings included: 1..At 11:45 AM on 7/19/2011, the Blood Bank was observed with two staff members in the room. One staff member was observed wearing a lab coat and blue latex gloves while the other staff member was observed not wearing any personal protection equipment. 2. At 12:00 PM. staff member L5 indicated all staff working in the Blood Bank must wear a lab coat and gloves for protection against possible blood exposure.		signage to designate this computer area as "CLEAN AREA NO PPE OR SPECIMENS IN THIS AREA." Staff were re-educated as to the proper attire in all areas of the Blood Bank.Ongoing compliance and monitoring:The Point of Care Coordinator will observe daily, and on a continual basis, that proper attire is worn in all areas of the Blood Bank. Staff failure to comply will result in employee counseling.	
S0612	410 IAC 15-1.5-2(f)(3)(D)(xi) (f) The hospital shall establish an infection control committee to monitor and guide the infection control program in the facility as follows: (3) The infection control committee responsibilities shall include, but not be limited to, the following: (D) Reviewing and recommending changes in procedures, policies, and programs which are pertinent to infection control. These include, but are not limited to, the following: (xi) A program of linen management for personnel involved in linen handling.	S0612	All lab coats within the room are	07/20/2011

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	Based on observation, the facility failed to store soiled lab coats in the Blood Bank in an area that would not contaminate clean lab coats. Findings included: At 11:45 AM on 7/19/2011, the Blood Bank was toured. The Blood Bank had a hamper for their soiled lab coats. It was observed leaning against clean lab coats that were hanging on wall hooks in the Blood Bank. One soiled lab coat was observed in direct contact with a clean lab coat.		considered as in use and dirty, whether on a hook or in the dirty laundry bag. Clean lab coats are stored on a rack outside of the Blood Bank Lab area. Once a tech gets a clean lab coat, they will wear it for several days before placing it into the soiled laundry bag to be sent out for cleaning. Once a clean lab coat is put on and worn in the testing area, the tech will remove the lab coat and place it on a coat hook prior to leaving the testing area. This process will prevent any further issues and all staff have been re-educated.Monitoring:The Point of Care Coordinator will observe daily on a continual basis that clean lab coats and dirty lab coat are not together. If there is a deficiency noted, the staff member will be immediately counseled.	
S1118	410 IAC 15-1.5-8 (b)(2) (b) The condition of the physical plant and the overall hospital environment shall be developed and maintained in such a manner that the safety and well-being of patients are assured as follows: (2) No condition shall be created or maintained which may result in a hazard to patients, public, or employees. Based on observation, the hospital created conditions which resulted in a hazard to patients, public or employees in 2 instances.	S1118	Actions for #1 ad #2:On 7/18/11, the acetylene tank that was found to be unsecured was removed immediately. Staff were re-educated on the risks of	07/20/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150154	A. BUILDING 00 B. WING	07/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA HEART HOSPITAL THE	8075 N SHADELAND AVE INDIANAPOLIS, IN46250

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	Findings: 1. On 7-18-11 at 11:20 am in the presence of employees #A6 and #A14, it was observed in the Boiler Room, there was 1 acetylene tank on the floor unsecured by chain or holder. 2. If the above tank was knocked over and broke the head off the compressed cylinder, it could result in harm to people and/or property. 3. On 7-18-11 at 12:30 pm in the presence of employees #A6 and #A14, it was observed in the offsite Cardiac Testing patient prep room there was an alcohol-based hand sanitizer (ABHS) on the wall directly over a light switch. 4. The ABHS, being directly over an electrical ignition source, posed a fire hazard if the flammable alcohol was sprayed or dropped into the electrical ignition source.		unsecured tanks.Ongoing compliance and monitoring:The Facilities Director, or his delegates, will observe on a daily basis that no acetylene tanks will be unsecured. Failure by any staff member to comply with the appropriate safety practice will result in employee counseling. Actions for #3 and #4:The hand sanitizer in the Cardiac Testing patient preparation room was removed immediately on 7/18/11. Staff were re-educated on the safety risks of flammable liquids near electrical switches and outlets.Ongoing compliance and monitoring:The Cardiac Testing Supervisor will observe on a daily basis that no hand sanitizers or flammable liquids are placed over light switches or electrical outlets. Failure by any staff member to comply with the appropriate safety practices will result in employee counseling.	

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S1150	410 IAC 15-1.5-8 (c)(9) (c) In new construction, renovations and additions, the hospital site and facilities, or nonlicensed facilities acquired for the purpose of providing hospital services, shall meet the following: (9) All back flow prevention devices shall be installed as required by 327 IAC 8-10 and the current edition of the Indiana plumbing code. Such devices shall be listed as approved by the department. Based on observation, the hospital failed to install backflow prevention devices as required by 327 IAC 8-10 and the current addition of the Indiana plumbing code in 1 instance. Findings: 1. On 7-18-11 at 3:00 pm in the presence of employee #A14, it was observed in Room 216 there was a flexible hose connected to a water spigot and the renal dialysis machine filter tank without a backflow preventor.	S1150	The backflow prevention device was installed in the room on 7/20/11 by Maintenance. The dialysis nurse is responsible for seeing that a backflow prevention device is on the equipment prior to utilization. Dialysis nurses were re-educated on the importance of the backflow prevention device and on their responsibility for assuring that one is installed prior to use.Ongoing monitoring and compliance:The Supervisor over Renal Dialysis is responsible for random, periodic checks to assure the nurses are compliant with this standard. Staff failure to comply will result in employee counseling.	07/20/2011

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S1164	410 IAC 15-1.5-8(d)(2)(B) (d) The equipment requirements are as follows: (2) There shall be sufficient equipment and space to assure the safe, effective, and timely provision of the available services to patients, as follows: (B) There shall be evidence of preventive maintenance on all equipment. Based on document review and interview, the hospital failed to provide evidence of preventive maintenance (PM) for 3 pieces of equipment. Findings: 1. On 7-18-11 at 10:15 am, employee #A1 was requested to provide documentation of PM on overhead adjustable (swing) lights in the operating rooms. 2. On 7-20-11 at 11:25 am, upon interview, employee #A14 indicated there was no documentation and none was provided prior to exit. 3. On 7-18-11 at 11:10 am, employee #A14 was requested to provide documentation of PM on a saw in the maintenance shop, Hitachi # CC14SF	S1164	Actions for #1 and #2 findings:The lights were brand new lights and hadn't been placed into the Preventive Maintenance (PM) system yet. They were subsequently entered into the system on 7/20/11 by the Facilities Director and remain on the inventory.Actions for #3 and #4 findings:The saw hadn't been placed into the Preventive Maintenance (PM) system yet and this was done during the survey on 7/20/11. The Facilities Director is responsible for the inventory of equipment and the ongoing compliance of the PM schedule on an on-going basis. He has re-educated clinical and non-clinical areas on the need to notify Clinical Engineering when new equipment is obtained so that it can be entered into the inventory.Actions for #5 and #6 findings:See attached response titled "TIHH Attachment A for S1164".All ongoing monitoring and compliance for PM inventory and scheduling is the	08/04/2011

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	4. On 7-20-11 at 11:25 am, upon interview, employee #A14 indicated there was no documentation and none was provided prior to exit. 5. On 7-18-11 at 11:45 am, employee #A14 was requested to provide documentation of PM on a pill packaging machine in the Pharmacy. 6. On 7-20-11 at 11:25 am, upon interview, employee #A14 indicated there was no documentation and none was provided prior to exit.		responsibility of the Facilities Director and his delegates.	